

**State Employee Benefits Committee
Friday, March 4, 2016 at 2:00 p.m.
Tatnall Building, Room 112
Dover, Delaware**

The State Employee Benefits Committee met on March 4, 2016, at the Tatnall Building, Room 112, Dover, Delaware. The following Committee members and guests were present:

Committee Members:

Ann Visalli, Director, OMB
Tom Cook, Finance
Geoff Klopp, COAD
Mike Morton, CGO
Evelyn Nestlerode, AOC Designee
Jennifer Vaughn, DOI Designee
Henry Smith, DHSS

Andrew Kerber, DOJ
Jeff Kitchen, Highmark
Kathy Kunkle, OMB/Pensions
Omar Masood, OST
Gisela McKenzi, Univ of DE
Mike North, Aetna
Casey Oravez, OMB, Financial Operations
Carol Parrish, Brandywine School District
Lori Peddicord, City of Dover
Karol Powers-Case, DRSPA
Pamela Price, Highmark
Rebecca Reichardt, OMB
Paula Roy, Roy Associates/DCSN
Sheri Sack, Aflac
Ann Skeans, Retiree
Donna Smallword, Brandywine School District
James Testerman, DSEA-R
Stuart Wohl, Segal Consulting

Guests:

Brenda Lakeman, Director, SBO
Faith Rentz, Deputy Director, SBO
Lisa Porter, SBO
Matt Bittle, DE State News
Lisa Carmean, City of Milford
Jessica Eisenbrey, OMB
Karin Faulhaber, PHRST
Judy Grant, HMS
Darcell Griffith, Univ of DE
Kim Hawkins, City of Dover
Angela Hua, Truven Consultant

Introductions/Sign In

Director Visalli called the meeting to order at 2:00 p.m. Anyone who had public comment was invited to sign up to provide comment at the end of the meeting. Introductions were made.

Approval of Minutes - handout

Director Visalli requested a motion to approve the minutes from the February 19, 2016 SEBC meeting. Controller General Morton made the motion and Secretary Cook seconded the motion. Upon unanimous voice vote the minutes were approved.

Director's Report

Ms. Lakeman provided an update on Telemedicine that the Board of Medical Licensing kept in place that audio only functionality is not allowed per the statute. Teladoc, the Aetna vendor, will not be using audio only but will still provide video teleconferencing to perform this service until the statute or regulation is changed or resolved.

The transition from Ceridian, the COBRA administrator, to WageWorks is proceeding with the contract finalized and the benefit representatives are being prepared to access the system to process any qualifying events.

The 1095C reporting is still being worked on for the active employees with test files sent to the vendor and we expect the forms to be sent out the last week of March.

State of Delaware Group Health Program – Overall Cost and Use – 6-Month Snapshot Tables

Advantage Suite Update – Paid Basis – handout

Ms. Rentz provided a follow up to the last meeting with the experience through Q2 FY16 as it had improved. This analysis on the differences between FY15 and FY16 was provided by Truven and includes high level data from all vendors (Highmark, Aetna and Express Scripts) for claims paid by the health plan in Q1 and Q2 of FY16. The outpatient costs for Actives and Early Retirees are down by 6.3% at the facility and 5.6% at the professional level compared to the prior period in FY15. This means less people are getting services but the cost for those services are still going up which is expected as seen in the trend but has improved over same period last year. Same information was shared for the Medicare-Eligible Retirees with services per member up slightly but the allowed amount per service is down by 1.2%. This suggests the severity or condition of these services being treated may be a little better than last year.

The same illustration was presented for Inpatient Cost and Trends. The average length of hospital stay has a considerable decrease of 4.4% for Actives and Early Retirees suggesting the severity of inpatient treatment has improved along with a 4.0% decrease in the allowed amount per admission, perhaps being treated for less severe conditions than in the prior period. The Medicare population shows a decrease in the length of stay at 3.2%. The allowed amount per admission is flat with a 1% increase in facility and a decrease of 2% in the professional category.

In comparing the first two quarters of FY16 with FY15, prescription drugs show a steady increase in the allowed amount in all categories for the Actives. Similar increases appear for the Medicare population. This is aligned with the trend assumptions that the premiums for the current year were set at a 15% trend was predicted. This overview shows better performance than predicted.

High Cost Claimants for Actives and Early Retirees were reviewed. FY15 Q1 and Q2 had a total of 426 claimants with average net pay per claimant of \$114,700. For same period in FY16, there is a decrease to 408 claimants with average net pay per claimant of \$104,020. High cost claimants of \$250K or more decreased from 20 claimants in the first half of FY15 to 8 claimants in the first half of FY16. Total claimants net pay decreased from \$45M to \$39M. Improvement is apparent with the Medicare-Eligible Retirees as there were 8 claimants reduced to 6 claimants in FY16. A big change in the average net pay per claimant is seen from \$145K in the prior period compared to \$84K in current period and there are no claimants over \$150K.

At the next meeting and as a follow up to the February 19th meeting, there will be discussion about DelaWELL with information about chronic disease conditions, trying to control these conditions which connects to this presentation to continue to keep the high cost claimants down. Secretary Cook inquired on the timing of these high cost claims in the review and payment process. Response included the percentage of electronic filing of claims is much better than five years ago reducing the turnaround time for claims. The majority of claims submitted are processed and usually paid within a month but a more detailed review or analysis of complex claims as well as claims on an incurred basis may be required. A pipeline view of these incoming high cost claims shown on both a paid and incurred basis would allow more of a sense of comfort or discomfort and help to quantify what some of the change in the trend has been.

FY Planning - handout

Ms. Lakeman provided a recap of the FY17 Planning presented at the last meeting in preparation to vote in a few weeks. The same projected expenditures were reviewed at \$852.7M through FY15 Q4. A savings of \$30.9M garnered from the prescription RFP contract starting July 1, 2016 and \$28.4M due to improved claim experience leaving the projected expenditures at \$793.4M through FY16 Q1. Adding the expected savings of \$37.2M from continued improvement of claims, this brings the projected expenditures to \$756.2M through FY16 Q2. The revenue projections based on FY2017 is \$736.8M, leaving a deficit of \$19.4M. At the end of Q1, the deficit was at \$56.6M. The claim liability deficit of \$25.9M and health fund reserve deficit of \$79M were reviewed. The FY17 Governor's Recommended Budget of \$33.3M General Funds equals \$56.6M based on the addition of the retiree and employee premiums and the non-State group and other funding. The \$56.6M will be allocated to \$19.4M FY17 operating fund, \$25.9M FY17 claim liability and \$11.3M FY17 reserve funding. The FY17 premiums were reviewed and the employee share increase would range from \$1.98 for an individual in the First State Basic Plan to a maximum of \$19.48 for a family in the Comprehensive PPO Plan. These are monthly rates so bi-weekly it would be half of what is shown and these rates are deducted on a pre-tax basis. The

Medicare rates would not change until January 1, 2017 and the increase is for Special Medicfill for Retirees retired on or after July 1, 2012. For subscriber with Rx, an increase of \$1.64 and with no Rx the increase would be \$0.92. Those retirees retired before July 1, 2012 would have no increase.

An option in the plan design change is to promote consumerism through High Tech Radiology Site of Service (MRI, CT scan). Highmark's approved High Tech Imaging provider is NIA. Member would be contacted if scheduled at hospital and informed that a lower cost option is available. Annual program fee of \$33,000 per year and this is limited to Delaware. Aetna can set up a custom network that would be established to steer provider to schedule at a freestanding clinic due to a \$0 copay to member. Communications both from State and Highmark/Aetna will be key. The current copay is \$50 for High Tech Radiology. The cost for reduction of copay to \$0 is estimated at \$200K if no change in behavior or movement from hospital based facilities to freestanding facilities. This does not include the \$33K annual program fees. Movement of approximately 300 visits would cover reduction in urgent care copay. Movement above 300 visits will result in average savings of \$800 per high tech test. The recommendation includes monitoring utilization for one year. If movement does not cover costs of copay reduction with additional savings, resume high tech copay for freestanding facilities effective January 1, 2018.

Another change option is to move utilization to urgent care from emergency room site of service. It was noted that if member is admitted through ER, the copay is waived. In FY2015 the use and cost without admissions increased at \$683K for urgent care and emergency room services increased \$5.5M. Some of the common clinical conditions could cost over 9 times as much to treat in the emergency room. To encourage member to utilize urgent care facilities, propose to lower copay to equal PCP copay for a year evaluation period. HMO plan copays would decrease from \$25 to \$15 and PPO plans from \$30 to \$20. The cost of the copay reduction is estimated at \$300K if no change in behavior or movement from ER to urgent care. Movement of approximately 200 visits would cover reduction in urgent care copay - \$300K copay reduction / \$1,434 difference in price. The recommendation is to monitor utilization for 1 year. If movement does not cover costs of copay reduction with additional savings, resume copay effective January 1, 2018. The need to educate members of the nearest urgent care facilities is needed. Highmark and Aetna to help communicate this information to members. Four options for members are to utilize 24/7 Nurse, Telemedicine, PCP and lastly urgent care. A list of urgent care centers is available on the SBO website for both Highmark and Aetna. It was asked for the providers when doing mailings, to utilize geo-access of urgent care centers by zip code to employee home addresses since some may be hidden in shopping centers and to help with member's awareness.

The next steps at the March 18th meeting are to vote on the recommended rate changes, vote on the proposed plan option changes that include Express Scripts (ESI) Over-the-Counter, ESI – Med B vs D coordination, ER/Urgent care steerage and copay change, High Tech Radiology steerage and copay change. Plan to continue discussion on FY17 DelaWELL and member engagement strategy.

Public Comment

Ms. Karol Powers-Case commented that she finally found a hospital freestanding urgent care facility in Middletown but upon calling, found it was purchased by CCHS. Ms. Lakeman to follow up on this as some freestanding urgent care facilities that are associated with hospitals are not necessarily the same as radiology in that they are charge a lower price.

Ms. Sheri Sacks of Aflac commented along the lines of education if 30,700 people are using ER facilities who are not being admitted, agrees 100% with education, but why not focus those messages and outreach to the specific population using ER facilities to alert them of the costs and make suggestions for another urgent care facility as members may not understand the difference and may not realize employer is aware which may help change behavior.

Ms. Paula Roy, Roy Associates shared personal experience of needing an MRI immediately. There are plenty of times when an ER visit is appropriate and admission is not appropriate (example broken bone). To follow the State Innovation model and movement toward the Patient Center Medical Home, is there communication back to the PCP when there was a visit there? Response was that we don't think that is happening right now with DHIN. Follow up will occur.

Motions

None

Other Business

Mr. Klopp commented that he is unsure how SEBC has integrated the cost drivers determined by the Health Plan Task Force and what the plan is moving forward to address those cost drivers, specifically the hospitals and their willingness to engage in discussion. Ms. Lakeman responded that several conversations have taken place with Christiana Hospital, Highmark and Aetna are conversing with the hospitals, continuing to talk with another presenter, ELAP, from the Task Force and continue to discuss possibilities to look at hospital charges but do not have any proposals or changes yet to bring forth. Director Visalli noted what is already happening with Accountable Care Organizations and the State Innovation model and will continue to happen. Some interest on the part of the Legislature is consistent with this and more information from the Centers of Excellence will be forth coming. It was noted that a briefing of the Findings of the Health Plan Task Force Committee was presented at the last day of the DHSS hearing. Controller General Morton stated that from a legislative perspective with respect to the issues raised from the Health Plan Task Force, even though nothing can be done between now and Open Enrollment, they will not let those issues go away.

Director Visalli stated the next SEBC meeting is scheduled for Friday, March 18, 2016.

A motion to adjourn the meeting was made. Controller General Morton made the motion and Mr. Smith seconded. Upon unanimous voice approval, the meeting was adjourned at 3:10 p.m.

Respectfully submitted,

Lisa Porter
Executive Secretary
Statewide Benefits Office